

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04963

CERTIFICATE OF DEATH

Item 14, Film G182, 5/27/55 rcy

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>California</i>		<i>3 yrs</i>		TOWN <i>California</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Ernest Graham Adcock</i>				<i>May 20 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M.</i>	<i>White</i>	<i>Married</i>	<i>Oct 29 1894</i>	<i>60 yrs.</i>	<i>6</i> Months	<i>21</i> Days	<i>0</i> Hours <i>0</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Laundry</i>		<i>Laundry</i>		<i>North Carolina</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Charles Adcock</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>3 No</i>		<i>577018489</i>		<i>ERNEST Adcock, 645 Connely Ave. San Francisco, Cal.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
450.0 IMMEDIATE CAUSE						<i>1 week</i>	
(A) DUE TO <i>Heart Failure</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.						<i>5 yrs.</i>	
(B) DUE TO <i>Generalized Arteriosclerosis</i>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 1, 1954</i> to <i>May 20, 1955</i> that I last saw the deceased alive on <i>May 20, 1955</i> , and that death occurred at <i>3:12 P.M.</i> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Mr. H. Patnick</i>		<i>Lexington Park Md.</i>		<i>May 20, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5/28/55</i>		<i>Forest Lawn - N. Oak</i>		<i>Virginia</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5/21/55</i>		<i>Glenn D. Nausey</i>		<i>Jos. C. Mattingly</i>		<i>Leontine</i>	

RECEIVED

MAY 24 1955

BUREAU V. 3

4962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04964
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 282

1. PLACE OF DEATH:

COUNTY **ST MARY'S** MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) **LEXINGTON PARK** LENGTH OF STAY (in this place) **4 1/2 yrs**

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **ST MARY'S**CITY (If outside corporate limits write RURAL and give nearest town) **LEXINGTON PARK**STREET ADDRESS (If rural, give location) **27 Lei Drive**

3. NAME OF DECEASED:

(First) **WILLIAM** (Middle) **MARSHALL** (Last) **BETTS**4. DATE OF DEATH **MAY 8, 1955**

5. SEX:

MALE

6. COLOR OR RACE:

WHITE7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **MARRIED**8. DATE OF BIRTH: **MAY 10, 1914**9. AGE last birthday: **40** yrs. IF UNDER 1 YEAR: **11** Months IF UNDER 24 HRS. **27** Days10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): **CARPENTER**10b. KIND OF BUSINESS OR INDUSTRY: **U.S. NAVY**11. BIRTHPLACE (State or foreign country): **NORTH CAROLINA**12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME:

JOHN WILLIAM BETTS

14. MOTHER'S MAIDEN NAME:

ALMA HUNT PORTER15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) **NO** (If Yes, give war or dates of service) **NONE**16. SOCIAL SECURITY No.: **238-01-3838**

17. INFORMANT & ADDRESS:

BERNICE BETTS 27 Lei Drive Lexington, PPK.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause(a) DUE TO **Coronary occlusion**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause DUE TO **Arterio-sclerosis**
(c) stating underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

1 day

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) **none**

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **none**21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John D. DavisCHIEF MEDICAL EXAMINER ☐ DATE SIGNED **5/9/55**
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

M. D.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF **5/11/55**NAME OF CEMETERY OR CREMATORY **OPEN**LOCATION (City, town, or county) **RALEIGH,****NORTH CAROLINA**DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **5/9/55**

24. FUNERAL DIRECTOR

JOS. C. MATTINGLEY**LEONARDTOWN, MD.**

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEDERAL BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE

BUREAU V. S.

MAY 11 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04965

CERTIFICATE OF DEATH

Reg. Dist. No. 282.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Rural Hermanville		LENGTH OF STAY (in this place) 50yrs		CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Rural Hermanville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED: (First) (Middle) (Last) William Henery Chase				4. DATE (Month) (Day) (Year) OF DEATH: May 29, 1955			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 12/11/1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months 5 Days 18	IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm			10B. KIND OF BUSINESS OR INDUSTRY: Day Labor		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Chase				14. MOTHER'S MAIDEN NAME: Mary Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT & ADDRESS: chase Mrs Henery Hermanville, Maryland	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Heart failure						1 week	
ANTECEDENT CAUSE (B) Hypertension						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized arteriosclerosis						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1949 to May 29, 1955 that I last saw the deceased alive on May 27, 1955 , and that death occurred at 805 M. from the causes and on the date stated above.							
SIGNATURE J. H. Patrick				ADDRESS Lexington Park, Md.		DATE SIGNED 5-29-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/1/55		NAME OF CEMETERY OR CREMATORY Holy Face		LOCATION (City, town, or county) (State) Great Mills Maryland	
DATE REC'D BY LOCAL REGISTRAR 5/31/55		REGISTRAR'S SIGNATURE Glean S. Hawser		24. FUNERAL DIRECTOR Jos. C. Mattingley		ADDRESS Leonardtwn, Md.	

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JUN 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04966

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Marys</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>St Marys</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bush Wood</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bush Wood</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>James Walter Lacey</u>				<u>May 9 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 24-1900</u>	9. AGE last birthday: <u>54</u> yrs.	IF UNDER 1 YEAR: Months <u>4</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Self Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MD St Marys</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Lacey</u>				14. MOTHER'S MAIDEN NAME: <u>Raddie Farrell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs Muriel M Lacey</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 hr.			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage.</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive Cardio-vascular disease</u>				10 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>54</u> to <u>May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5 May</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bell</u>		ADDRESS <u>Leonardtown, MD</u>		DATE SIGNED <u>5/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) <u>Bush Wood MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>Wanda Houser</u>		24. FUNERAL DIRECTOR <u>W E Wallingley</u>		ADDRESS <u>Leonardtown, MD</u>	

BUREAU V. S.

MAY 12 1955

RECEIVED

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 1,7,8,9,10a,b,11,13,14 Information given by Funeral Director 5/20/55				4967	
4965 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No.	
I. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>St. Mary's</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>St. Mary's</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u>		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> <u>47X-3</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 235</u>			STREET ADDRESS (If rural, give location) <u>Route 235</u>		
3. NAME OF DECEASED: (First) <u>JOHN</u>		(Middle) <u>LANCASTER</u>	4. DATE OF DEATH		(Month) <u>5</u> (Day) <u>16</u> (Year) <u>19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11-27-1902</u>		9. AGE last birthday: <u>52</u> yrs. <u>5</u> Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Truck Driver</u>	11. BIRTHPLACE (State or foreign country): <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>John E. Lancaster</u>			14. MOTHER'S MAIDEN NAME: <u>Sarah E. Palmer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Georgianna Boone -sister</u>
18. MEDICAL CERTIFICATION			815 F St. S.W.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
353.3 Immediate cause (a) <u>Epilepsy</u>					
DUE TO					
Antecedent cause(s) (b) <u>DUE TO</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>William J. Boone</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/17/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		DATE REC'D BY LOCAL REG. <u>5-20-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>John E. Roberson #75</u>		ADDRESS <u>1313-28th St. N.W. Wash. D.C.</u>			

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF PHYSICS
PHYSICS 101

NAME _____

DATE _____

SECTION _____

LABORATORY _____

INSTRUCTOR _____

ASSISTANT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

STUDENT _____

4966

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:

COUNTY **St Mary's**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) **Leonardtwn**LENGTH OF STAY (in this place) **25 Yrs.**HOSPITAL OR INSTITUTION OR STREET ADDRESS **Hospital St Mary's**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **St Mary's**CITY (If outside corporate limits, write RURAL and give nearest town) OR **Leonardtwn**

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) **Benedict Booth Love Jr.**

4. DATE (Month) (Day) (Year)

OF DEATH: **May 14, 1955**

5. SEX:

Male

6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Married**

8. DATE OF BIRTH:

August 22, 1901

9. AGE last birthday

53 yrs.

IF UNDER 1 YEAR

8 Months**22** Days**22** Hours**Min.**10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Saleman**10B. KIND OF BUSINESS OR INDUSTRY: **Bottle Gas**11. BIRTHPLACE (State or foreign country): **Maryland**12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME:

Benedict B. Love Sr.

14. MOTHER'S MAIDEN NAME:

May Graves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates)

yes **WORLD WAR I**

16. SOCIAL SECURITY NO.

213-10-9793 Katherine M. Love Leonardtown, Md.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0

IMMEDIATE CAUSE

(A) DUE TO **cirrhosis of liver**

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. **audible**

INTERVAL BETWEEN ONSET AND DEATH

1 year

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory, street, office bldg., etc.) **none**21C. WHERE DID (City or town) INJURY OCCUR? **none**

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **none**

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/2**, 19**55**, to **5/14**, 19**55**, that I last saw the deceasedalive on **5/13**, 19**55**, and that death occurred at **6:00A.M.** from the causes and on the date stated above.SIGNATURE **Law**ADDRESS **Leigla Park, Md**DATE SIGNED **5/16/55**

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial**DATE THEREOF **5/16/55**NAME OF CEMETERY OR CREMATORY **St Aloysius**LOCATION (City, town, or county) **Leonardtwn, Maryland**

(State)

DATE REC'D BY LOCAL REGISTRAR **5/15/55**REGISTRAR'S SIGNATURE **Clarence A. House**

24. FUNERAL DIRECTOR

ADDRESS

Jos. C. Mattingley Leonardtown, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0496982

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St. Mary's</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>St. Mary's</i>	
CITY (If outside corporate limits, write RURAL OR TOWN <i>Mechanicville</i>)		LENGTH OF STAY (in this place) <i>4 5/8 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Mechanicville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>R.F.D.</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <i>August</i>		(Middle)		(Last) <i>Stasch</i>		<i>5 1 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
		<i>Married</i>	<i>Jan 6 - 1880</i>	<i>75</i> yrs.	Months <i>3</i>	Days <i>23</i>	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Farmer</i>		<i>Farming</i>		<i>Berlin Germany</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>No</i>						<i>August Henry Stasch</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
151X IMMEDIATE CAUSE (A) DUE TO <i>Carcinoma of Stomach</i>				<i>1 year?</i>			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>1 Nov 54</i>		<i>Advanced carcinoma of stomach</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work or Not while at work		21F. HOW DID INJURY OCCUR?			
		<input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work					
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <i>3:45 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. Roy Gaylor</i>		ADDRESS <i>Mechanicville, Md.</i>		DATE SIGNED <i>5/1/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 3 1955</i>		<i>St Paul Fisher</i>		<i>Wm. Market St Mary's Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5/3/55</i>		<i>Alan D. Hauser</i>		<i>J. C. Malins</i>		<i>Leor and Son Md</i>	

RECEIVED

MAY 6 1935

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Items 18 Film 9102 0-5-55 ans

04970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>SAINT MARY'S</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>ST. MARY'S</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>LEXINGTON PARK</u>		TOWN <u>LEXINGTON PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>18 LEI DRIVE</u>		STREET ADDRESS (If rural, give location) <u>18 LEI DRIVE</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>GEORGE</u>	(Middle) <u>Russell</u>	(Last) <u>STEWART</u>	(Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>8-7-1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>PUMP OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>CIVIL SERVICE</u>	9. AGE last birthday: <u>47</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>KANSAS CITY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>OLIVER P. STEWART</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO.: <u>—</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>MRS. DEBORAH STEWART, LEX. PARK, MD.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
322.0 Immediate cause (a) <u>Respiratory depression</u>			
DUE TO			
Antecedent cause(s) (b) <u>acute alcoholism while under morphine sedation</u>			
Diseases or conditions, if any, giving rise to the above cause (c) <u>Pulmonary tuberculosis</u>			
DUE TO			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>P.B. Robinson</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-25-55</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>CREMATION</u>	DATE THEREOF: <u>5-27-55</u>	NAME OF CEMETERY OR CREMATORY: <u>WM. LEE'S CREMATORY</u>	
LOCATION (City, town, or county) (State): <u>WASHINGTON, D.C.</u>	24. FUNERAL DIRECTOR: <u>P.B. Robinson</u>	ADDRESS: <u>LEONARDTOWN, MD.</u>	
DATE REC'D BY LOCAL REG. <u>5-26-55</u>	REGISTRAR'S SIGNATURE: <u>P.B. Robinson</u>		

RECEIVED

MAY 31 1955

BUREAU V. S.

RECEIVED FOR DEPT. OF JUSTICE

4969

CERTIFICATE OF DEATH

Reg. Dist. No. 04971

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Marys</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Marys</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <i>Leonardtown</i>		<i>23 days</i>		OR TOWN <i>Leonardtown</i>		<i>md x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>78 St Marys Hospital</i>				<i>md x</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
<i>(First) Mary (Middle) Lillian (Last) Swales</i>				<i>May 1 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>Colored</i>	<i>Married</i>	<i>May-15-1818</i>	<i>36</i> yrs.	<i>11</i> Months	<i>16</i> Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>nurse maid</i>						<i>Maryland St Marys</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>George Henry Swales</i>				<i>Emma Young</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>9</i>				<i>220-32-5893</i>		<i>Mr Catherine Bowman Leonardtown md</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
445X IMMEDIATE CAUSE (A) <i>uraemia</i>							<i>1 mo.</i>
ANTECEDENT CAUSE (S) DUE TO (B) <i>Malignant Hypertension</i>							<i>1 yr.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>None</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
				<i>none</i>		<i>none</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<i>none</i>				<i>none</i>			
22. I hereby certify that I attended the deceased from <i>4/20</i> , 19 <i>55</i> , to <i>5/1</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/20</i> , 19 <i>55</i> , and that death occurred at <i>6:20 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Alan S. Bauer</i>				ADDRESS <i>Leignton Rd. Md</i>		DATE SIGNED <i>5/1/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>5-4-55</i>		<i>Ours Lacks</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/3/55</i>				REGISTRAR'S SIGNATURE <i>Alan S. Bauer</i>		24. FUNERAL DIRECTOR <i>Jos E. Mattingly</i>	
						ADDRESS <i>Leonardtown md</i>	

MARGIN RESERVED FOR BINDING

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RECEIVED

MAY 6 1955

BUREAU V. S.